STATE OF IDAHO PATIENT FREEDOM OF INFORMATION ACT

PROVIDER INITIAL REPORT FORM

idaho Code §54-4603 requires that every applicant for licensure or registration and every currently licensed or registered Chiropractor, Dentist, Nurse Practitioner, Certified Registered Nurse Anesthetist, Optometrist, Physician, Surgeon, Physicians' Assistant, Physical Therapist, Podiatrist, and Psychologist furnish the following information prior to the issuance or renewal of a license or registration: (Use additional pages, clearly labeled by section letter, if more space is necessary.)

LICENSEE -					
(license number)	M	O-			
(name)					
(address)					
(city, state, zip)	***				
(date of birth m/d/yyyy)					
•					
A. EDUCATION -					
			·		
City Graduation date					
Graduation date					
Internship					
City		State			
Completion date					
,					
<u>=</u>					
City		State			
Completion date					
Fellowships, etc					
Otto.		State			
Psychiatry			included.		
C. SPECIAL POSITIONS - Appointments to graduate education within the most received.			nool and indication whether y	ou have had a respon	nsibility for
Position		School			
					
D. LOCATION & PRACTICE HISTORY - L				ent location of your pr	imary practic
setting. If more than 1 setting, include the	ie approximate p	percentage of time spen	t at each location.		
Current facility name				%	
City			State		
Type of practice			w contint		
Beginning & ending date		- <u>Present</u>			
Most recent past facility name				%	
City			State		
Type of practice					
Beginning & ending date		-			
PFIA-Provider Initial Report Form – Version 1.3			in the second set of the		
		1			

Past facility name								%	
City							State		
Type of practice									
Beginning & ending	g date								
Some of my practic	ce was locum te	nens durin	g part of t	he pas	st 10 yea	ars			
	[]Yes	[] No	Υ	'ears					
E. PRIMARY ADMITTING in good standing Facility name	HOSPITAL - The I		serves as y				ity and at which yo	ou have <i>ACT</i>	IVE clinical privileges
City							State		
F. MEDICAID / MEDICAR	Ë-								
Do you participate Do you participate		[]Yes []Yes	[] No E [] No E	ver be	een barr een barr	ed from ed from	participation? participation?	[]Yes []Yes	[] No [] No
G. TRANSLATING SERVI What language	CES – Do you prov	vide any tran	slating servi	ces? (optional)				
H. CRIMINAL HISTORY - I For purposes of this sub competent jurisdiction List conviction descr	section, you shall b	e deemed c	onvicted of	a crime	if you ple	d guilty o	r were found or ac	ljudged guilty	st recent 10 years. y by a court of
Charge					Date_				
I. BOARD DISCIPLINARY taken against you by AN	HISTORY - Descri IY board from <u>ANY</u>	ption of any state within	final discipli the most red	nary ac cent 10	tions, incl years	uding but	not limited to revo	ocation or sus	spension of license,
List disciplinary action	on						State		
Charge				-	Date_			<u> </u>	
J. OTHER DISCIPLINARY credentialing for more that been afforded; or your resof or in settlement of a pe	n 180 days, from <u>A</u> signation from or no	<u>.NY</u> state, for on-renewal o	reasons re f a medical s	lated to staff me	your com	petence	or character, after estriction of your p	procedural or	lue process has hospital taken in lieu
List privilege sanction	<u> </u>				Date				
Hospital			_ R	easor	1				
K. PROFESSIONAL LIABII	LITY INSURANCE	_							
Do you carry profess					[] Yes	[] No			
Have you ever been			ty insurand	ce?	[] Yes	[] No			
L. MALPRACTICE HISTOR awarded to a complaining	RY - Disclose all ma g party during the r	itpractice cou nost recent 1	urt judgment 10 years. Dis	s and a sclosure	all malprade of pendi	ctice arbiti ng malpra	ration awards aga actice claims is no	inst you in wl t required.	nich a payment was
List judgment		1011-11	. A	ward	\$		Date		

Percentage ____

- M. SETTLEMENT HISTORY Disclose all settlements of professional malpractice claims against you within the most recent 5 years of continuous practice:
 - (i) You need only disclose malpractice settlements if there have been 5 or more settlements in the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice of any dollar amount:
 - (ii) Settlements that result solely in an adjustment to the fee charged for your services shall not be disclosed pursuant to this chapter;
 - (iii) Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of a provider. A payment in settlement of a malpractice action or claim should not be construed as creating presumption that malpractice has occurred. Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation.";
- (iv) Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding settlements; List settlement____ Award \$_____ Date____ N. PROFESSIONAL OWNERSHIP - Disclose the percentage of ownership interest you have in other health facilities, laboratories, equipment or therapy, except for ownership interest in the primary practice business, to which your patients are, have been, or may be referred. Facility name ______

I hereby swear (or affirm) under oath that the information provided above is true and correct to the best of my knowledge. I understand that neither the Board that issues my license/registration nor the entity providing the profile shall be held liable for the correctness or completeness of the information contained in my profile. I further understand that any release of the information provided by me will include a disclaimer statement attesting to the self-reporting nature of the program, and that the information has not been verified by the board or the reporting entity. I further understand that my failure to provide a full and truthful disclosure of information to the board within the time specified, may result in a fine of up to fifty dollars (\$50.00) for each day that I am not in compliance with the requirement to report and that the board may take any other disciplinary action it deems appropriate, except the board may not revoke, suspend, refuse to issue or refuse to renew a license or registration solely because I failed to comply with the requirement to report.

	Licensee signature
State of, County of	, SS.
Subscribed and sworn before me this day of	, 20
(seal)	
	Notary Public official signature Residing at
	My commission expires

Return Profile Form to:

IDACARE PO Box 83720 Boise, ID 83720-0058

STATE OF IDAHO PATIENT FREEDOM OF INFORMATION ACT

PROVIDER INITIAL REPORT FORM

Idaho Code §54-4603 requires that every applicant for licensure or registration and every currently licensed or registered Chiropractor, Dentist, Nurse Practitioner, Certified Registered Nurse Anesthetist, Optometrist, Physician, Surgeon, Physicians' Assistant, Physical Therapist, Podiatrist, and Psychologist furnish the following information prior to the issuance or renewal of a license or registration: (Use additional pages, clearly labeled by section letter, if more space is necessary.)

LICENSEE -				
(license number)	PA			
(name)	Name of the United States			
(address)				
(city, state, zip)				
(date of birth m/d/yyyy)				
A. EDUCATION –				
City		State		'
O 1 11 1 1				
B. SPECIALTY CERTIFICATIONS - Specia	<u>-</u>	· ·	Board	
C. SPECIAL POSITIONS - Appointments to graduate education within the most rece	o faculty of any medical/		and indication whether you h	nave had a responsibility for
· ·	•			
Position	Sch	ool		
D. LOCATION & PRACTICE HISTORY - Locating. If more than 1 setting, include the Current facility name City Type of practice Beginning & ending date	ne approximate percenta	ge of time spent at e	ach location.	ocation of your primary practice %
Most recent past facility name	*11 - M			%
City			State	
Type of practice		•		
Beginning & ending date	-			
Past facility name				%
City			State	
Type of practice	100			
Beginning & ending date		-		
E. MEDICAID / MEDICARE -				
Do you participate in medicaid?	[]Yes []No	Ever heen harre	ed from participation?	[]Yes []No
Do you participate in medicare?			ed from participation?	[] Yes [] No
= >) = = = = = = = =	[] []			
TRANSLATING SERVICES - Do you po	rovide any translating se	rvices? (optional)		
What language				

PFIA-Provider Initial Report Form - Version 1.3

Charge	For com	purposes of this subsection, you shall be deemed convicted petent jurisdiction conviction description	of a crime	if you pled	guilty or	were found or adju	udged guilty by	a court of
List disciplinary action				Date			_	
I. OTHER DISCIPLINARY HISTORY - Description of any revocation or involuntary restriction of your hospital privileges, or a reduction in your credentialing for more than 180 days, from ANY state, for reasons related to your competence or character, after procedural due process has been afforded; or your resignation from or non-renewal of a medical staff membership, or the restriction of your privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to your competence or character in that hospital, within the most recent 10 years List privilege sanction	H. BO	ARD DISCIPLINARY HISTORY - Description of any final dison against you by <u>ANY</u> board from <u>ANY</u> state within the most	ciplinary a recent 10	ctions, inc years	luding but	not limited to revo	ocation or suspe	nsion of license,
I. OTHER DISCIPLINARY HISTORY - Description of any revocation or involuntary restriction of your hospital privileges, or a reduction in your credentialing for more than 180 days, from ANY state, for reasons related to your competence or character, after procedural due process has been afforded; or your resignation from or non-renewal of a medical staff membership, or the restriction of your privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to your competence or character in that hospital, within the most recent 10 years List privilege sanction	List	disciplinary action				_State		
credentialing for more than 180 days, from AN' state, for reasons related to your competence or character, after procedural due process has been afforded; or your resignation from or non-renewal of a medical staff membership, or the restriction of your privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to your competence or character in that hospital, within the most recent 10 years List privilege sanction	Cha	arge		Date				
J. PROFESSIONAL LIABILITY INSURANCE - Do you carry professional liability insurance? [] Yes [] No Have you ever been denied professional liability insurance? [] Yes [] No K. MALPRACTICE HISTORY - Disclose all malpractice court judgments and all malpractice arbitration awards against you in which a payment was awarded to a complaining party during the most recent 10 years. Disclosure of pending malpractice claims is not required. List judgment	crede been of or i	entialing for more than 180 days, from ANY state, for reasons afforded; or your resignation from or non-renewal of a medic in settlement of a pending disciplinary case related to your co	related to cal staff me ompetence	your comembership or charac	petence of , or the rest eter in that	or character, after particition of your pri thospital, within the	procedural due ivileges at a hos le most recent 1	process has spital taken in lieu
Do you carry professional liability insurance? [] Yes [] No Have you ever been denied professional liability insurance? [] Yes [] No K. MALPRACTICE HISTORY - Disclose all malpractice court judgments and all malpractice arbitration awards against you in which a payment was awarded to a complaining party during the most recent 10 years. Disclosure of pending malpractice claims is not required. List judgment	Hosp	oital	Reasor	າ				
L. SETTLEMENT HISTORY - Disclose all settlements of professional malpractice claims against you within the most recent 5 years of continuous practice; (i) You need only disclose malpractice settlements if there have been 5 or more settlements in the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice, of \$50,000, or more, per settlement 5 years of continuous practice, of \$50,000, or more, per settlement to the fee charged for your services shall not be disclosed pursuant to this chapter; (iii) Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of a provider. A payment in settlement of a malpractice action or claim should not be construed as creating presumption that malpractice has occurred. Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation."; (iv) Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding settlements; List settlement Award Award Award Date Award Awa	Do Hav K. M AL	you carry professional liability insurance? ye you ever been denied professional liability insur- PRACTICE HISTORY - Disclose all malpractice court judgm	ance?	[] Yes all malpra	[] No	ration awards agai octice claims is not	nst you in which required.	ı a payment was
practice; (i) You need only disclose malpractice settlements if there have been 5 or more settlements in the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice of any dollar amount; (ii) Settlements that result solely in an adjustment to the fee charged for your services shall not be disclosed pursuant to this chapter; (iii) Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of a provider. A payment in settlement of a malpractice action or claim should not be construed as creating presumption that malpractice has occurred. Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation."; (iv) Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding settlements; List settlement	Lis	st judgment	Award	\$		Date		
M. PROFESSIONAL OWNERSHIP - Disclose the percentage of ownership interest you have in other health facilities, laboratories, equipment or therapy, except for ownership interest in the primary practice business, to which your patients are, have been, or may be referred.	prac (i) (ii) (iii)	rectice; You need only disclose malpractice settlements if there have of \$50,000, or more, per settlement, or if there have been many dollar amount; Settlements that result solely in an adjustment to the fee ch. Information concerning all settlements shall be accompanie reasons which do not necessarily reflect negatively on the p. malpractice action or claim should not be construed as creatively by specialty. Some specialties are more likely than other	e been 5 c nore than ' arged for y d by the fo professiona iting presu ers to be t	or more se 10 settlem your service ollowing st al compete imption that the subject	ttlements i ents within ces shall n atement: ence or co at malprac of litigatio	in the most recent on the most recent of the disclosed purification. "Settlement of a claudict of a provide tice has occurred. on.";	t 5 years of cont 5 years of continuant to this claim may occur r. A payment in Malpractice his	tinuous practice, nuous practice of napter; for a variety of settlement of a tories tend to
therapy, except for ownership interest in the primary practice business, to which your patients are, have been, or may be referred.	Lis	st settlement	Award	\$		Date		
Facility name Percentage								
	Fac	ility name				Percentage _		

I hereby swear (or affirm) under oath that the information provided above is true and correct to the best of my knowledge. I understand that neither the Board that issues my license/registration nor the entity providing the profile shall be held liable for the correctness or completeness of the information contained in my profile. I further understand that any release of the information provided by me will include a disclaimer statement attesting to the self-reporting nature of the program, and that the information has not been verified by the board or the reporting entity. I further understand that my failure to provide a full and truthful disclosure of information to the board within the time specified, may result in a fine of up to fifty dollars (\$50.00) for each day that I am not in compliance with the requirement to report and that the board may take any other disciplinary action it deems appropriate, except the board may not revoke, suspend, refuse to issue or refuse to renew a license or registration solely because I failed to comply with the requirement to report.

	Licensee signature
State of, County of	, ss.
Subscribed and sworn before me this day	of, 20
(seal)	
	Notary Public official signature Residing at
	My commission expires

Return Profile Form to:

IDACARE PO Box 83720 Boise, ID 83720-0058

STATE OF IDAHO PATIENT FREEDOM OF INFORMATION ACT

PROVIDER INITIAL REPORT FORM

Idaho Code §54-4603 requires that every applicant for licensure or registration and every currently licensed or registered Chiropractor, Dentist, Nurse Practitioner, Certified Registered Nurse Anesthetist, Optometrist, Physician, Surgeon, Physicians' Assistant, Physical Therapist, Podiatrist, and Psychologist furnish the following information prior to the issuance or renewal of a license or registration: (Use additional pages, clearly labeled by section letter, if more space is necessary.)

(license number) (name) (address) (city, state, zip)	PT		
(address) (city, state, zip)			
(city, state, zip)			
(date of birth m/d/yyyy)			
A. EDUCATION –			
Physical Therapy School City	State		
^			
			Parks but a back
B. SPECIAL POSITIONS - Appointments a responsibility for graduate education	s to faculty of any medical/profe	essional school and in	dication whether you have ha
a responsibility for graduate education	i within the most recent to year	s (optional)	
Position	School		
1 0010011		,	
of your primary practice setting. If more			
of your primary practice setting. If more location. <u>Current</u> facility name City		proximate percentage	
of your primary practice setting. If more location. Current facility name City Type of practice	e than 1 setting, include the ap	proximate percentage	e of time spent at each
of your primary practice setting. If more location. <u>Current</u> facility name City	e than 1 setting, include the ap	proximate percentage	e of time spent at each
of your primary practice setting. If more location. Current facility name City Type of practice Beginning & ending date	e than 1 setting, include the ap	proximate percentageState	e of time spent at each %
of your primary practice setting. If more location. Current facility name City Type of practice Beginning & ending date Most recent past facility name	e than 1 setting, include the ap	proximate percentageState	e of time spent at each
of your primary practice setting. If more location. Current facility name City Type of practice Beginning & ending date Most recent past facility name City	e than 1 setting, include the ap	proximate percentageState	e of time spent at each %
of your primary practice setting. If more location. Current facility name City Type of practice Beginning & ending date Most recent past facility name	e than 1 setting, include the ap	proximate percentage State State	e of time spent at each %
of your primary practice setting. If more location. Current facility name City Type of practice Beginning & ending date Most recent past facility name City Type of practice	e than 1 setting, include the ap	proximate percentage State State	e of time spent at each %
of your primary practice setting. If more location. Current facility name City Type of practice Beginning & ending date Most recent past facility name City Type of practice Beginning & ending date Past facility name	e than 1 setting, include the ap	proximate percentage State State	e of time spent at each %
of your primary practice setting. If more location. Current facility name City Type of practice Beginning & ending date Most recent past facility name City Type of practice Beginning & ending date Past facility name City Past facility name City	e than 1 setting, include the ap	proximate percentage State State State	% %
Current facility name City Type of practice Beginning & ending date Most recent past facility name City Type of practice Beginning & ending date	e than 1 setting, include the ap	proximate percentage State State State State	% %

1

PFIA-Provider Initial Report Form - Version 1.3